Montana 1115 Family Planning New Demonstration Proposal
CMS- Follow-up Questions
December 27, 2011

Eligibility Requirements

1) Please confirm the eligibility requirements for the Demonstration population.
    a. Women ages 19-44, non pregnant, with household incomes at or below 200% of the Federal poverty level and not otherwise enrolled in Medicaid.
    b. MT resident.
    c. US citizen or qualified non citizen
    d. The State will not apply an asset test.
    e. The State will apply a $120 disregard from each household member's earned income. Up to $200 disregard per dependent per month of child or adult dependent care paid and a disregard to all child support paid by applicant or husband. Also, please confirm if the State uses the same disregard in its Medicaid State Plan.

    Response: Montana confirms the eligibility requirements listed in (1). Montana is using the same disregards for the Family Medicaid eligibility category as in its Medicaid State Plan. In addition, the State of Montana opts to keep the creditable coverage requirement as discussed in (3) below.

2) Please confirm the Demonstration population and its determination processes:
    a. Women ages 19-44, with a household income at or below 200% of the Federal poverty level- this population must complete an application for eligibility.

    Response: This is correct

    b. Women losing Medicaid coverage 60 days post partum- this population is *auto enrolled into the Demonstration upon losing Medicaid pregnancy coverage.*

    Response: HMK provides lists of those women aging out (19yrs/1mo) and they are sent a Plan First Outreach Notice. Outreach Notice includes: a brochure describing covered services and how to access services and a Plan First application. We will continue to seek a way to get a CHIMES list of women losing Medicaid when their post-partum coverage ends, however we are not auto enrolling populations at this time.

3) The State in its email response on October 6, 2011 indicates that the State would like to remove "creditable coverage" as an eligibility requirement for the Demonstration population. However in the "MI version Plan First Elig as of 10.07.2011" document, the State indicates on C17 that "applicants cannot presently have any other coverage for family planning services", which in terms means to include creditable coverage as an eligibility requirement. Can the State please clarify if it would like to remove the "creditable coverage" requirement that restricts individuals with health insurance coverage that includes family planning services from eligibility for the Demonstration? The "creditable coverage" requirement is at the State's option to include.

    Response: The State of Montana opts to keep the creditable coverage requirement.

Eligibility Determination, Redetermination Systems and Processes

4) Describe the role that providers will play in eligibility determinations (e.g. beneficiary education, assistance with mailing the application, etc.).

   Response: Providers may assist with on-line or paper application completion and mailing. If acceptable to CMS, providers may assist by asserting authenticity with confirmation of identity and citizenship when submitting supporting electronically submitted documentation.

5) What systems/processes will the State use to assist with the determination and redetermination of Demonstration eligibles?

   Response: Montana will determine and re-determine eligibility outside of any computer system but has created tools such as an eligibility criteria worksheet and enrollment status spreadsheets. Montana has developed an on line process to capture and transmit application information and will use this data to determine and transmit eligibility information to the MMIS for use in claims payment.

6) For administrative redeterminations, please describe what data the State will examine and use to populate the form.

   Response: Montana will populate the application form with the previous year application data. Applicants will need to confirm accuracy and make any relevant changes.

7) What is the period of "reasonable opportunity" for citizenship documentation in the application process?

   Response: 30 days.

8) The State has indicated that it would like to seek an enrollment cap of 4,000 individuals per Demonstration year. Will the State be instituting a waitlist? If so, how will this waitlist be handled?

   Response: Yes, the first applicants on the list will be the first off. The waitlist is maintained by date of receipt of application.

9) Please confirm that the State will be providing 12 months of continuous eligibility.

   Response: Yes, the State will be providing 12 months of continuous eligibility.

   a. Will the State require Demonstration enrollees to report changes, such as income, change of household members, etc, throughout the 12 months of continuous eligibility?

      Response: No.

      If so, will the State re-determine the enrollee's eligibility status within the 12 months?

      Response: NA

10) The State notes that each enrollee will receive an ID card associated with the Demonstration. In the State's initial application, on page 5, the State indicates that the enrollee has a choice to receive the ID or not. Is the State still planning to implement this choice?

    Response: No. All clients will receive identification of enrollment in the program.

If so, how will the enrollee be able to receive services if she decides not to receive an ID card associated with the Demonstration?
Response: NA

Enrollment and Projections

11) Please provide an estimate of the average monthly enrollment for the Demonstration extension period (for example, a certain percentage increase in enrollment each year).

Response:

Monthly caseload growth for FP waiver is estimated at :	
Month 1	**1724**
Month 2	**2776**
Month 3	**3722**
Month 4 and beyond	**4000**

It is expected that the enrollment cap will be met in the first year and will be met each year of the demonstration extension period.

Budget Neutrality

12) In the administration cost worksheet, the State indicates that there will be $100,000 used for system changes. Please describe what type of changes (and for what purpose) the State will implement this project and the timeline of completion of the system change.

Response: Montana has developed an on line application process to simplify the collection and transmission of the application via a secure web portal. This process will be complete by February 2012 and was developed at a cost of $85,000. Montana is also making changes to its MMIS system to create a Family planning plan of benefits and modify the system to process claims and report expenditures appropriately. These changes will also be complete by February 2012 and were estimated at approximately $15,000.

13) In the "Modeled Budget Neutrality Worksheet", please describe why the "Deliveries under Medicaid State Plan" (line 9 and 24) exceeds the number of person enrolled in the "Family Planning Services under Medicaid State Plan" (line 5 and 20)?

Response: The number of persons enrolled in family planning services under the Medicaid State Plan represents those individuals actually receiving family planning services in the base year and trending that information forward for prospective periods. It does not represent the total Medicaid eligible's as this number would include age cohorts that do not receive family planning services. In addition this number is used to compute the cost per person participating, therefore including only those receiving services results in the most accurate cost per participant calculation. The deliveries under the Medicaid State Plan represent individuals who had claims for the delivery of a child. While this population cohort may overlap those receiving family planning services, both cohorts are subsets of Medicaid eligibles and the number of births may exceed the number of persons receiving family planning services.

Standard Funding Questions

Please provide answers to the following standard funding questions as applicable to your Demonstration.

14) What will be the source of funds that make up the non-Federal share of the Demonstration?

Response: The state share is general fund dollars appropriated by the state legislature.

15) Section 1903(a) (1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 percent of the payments for services rendered or coverage provided.
    - Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)? Response: Providers retain 100% of the payment received through the fee for service payment methodology.
    - Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization?
      Response: NA, the state share is general fund dollars appropriated by the state legislature.
    - If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).
      Response: NA

16) Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.
    - Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.
      Response: All reimbursements to providers under the state share are general fund dollars appropriated by the state legislature.
    - Please describe whether the NFS comes from appropriations by the State Legislature, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.
      Response: The state share is general fund dollars appropriated by the state legislature to the Department of Public Health & Human Services.
    - Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.
      Response: NA

- If any of the NFS is being provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.
  Response: NA
- If CPEs are used, please describe how the State verifies that the expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).
  Response: NA
- For any payment funded by CPEs or IGTs, please provide the following:
  - a complete list of the names of entities transferring or certifying funds;
  - the operational nature of the entity (state, county, city, other);
  - the total amounts transferred or certified by each entity;
  - clarify whether the certifying or transferring entity has general taxing authority; and
  - whether the certifying or transferring entity received appropriations (identify level of appropriations).

  Response: NA

17) Section 1902(a) (30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: This demonstration does not require supplemental or enhanced payments.

18) Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

    Response: NA

19) Does any public provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services? Response: No, not applicable to this demonstration.
    - In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)
    - If so, how do these arrangements comply with the limits on payments in §438.6(c) (5) and §438.60 of the regulations?
    - If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?